



**Authorization for Release of
Medical Information to VUMC**
Authorization (P) - Release of Medical Information

PATIENT IDENTIFICATION	Name: _____ Date of Birth: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Previous Name: _____
	Patient Phone: _____

RELEASE RECORDS TO: Vanderbilt University Medical Center	
<input type="checkbox"/> Mail <input type="checkbox"/> Pick up in person <input type="checkbox"/> Fax <input type="checkbox"/> Electronic	Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____ Fax#: _____

RELEASE RECORDS FROM:	
Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____ Fax#: _____	

INFORMATION REQUESTED:

DATES OF TREATMENT TO BE RELEASED	
Dates from : _____ to _____ Or specific date: _____	
<input type="checkbox"/> Abstract <input type="checkbox"/> Legal medical record	
OR Specific Categories	
<input type="checkbox"/> History and physical <input type="checkbox"/> Discharge summaries <input type="checkbox"/> Operative/procedure notes <input type="checkbox"/> Consultations	<input type="checkbox"/> Radiology reports <input type="checkbox"/> Cardiac reports <input type="checkbox"/> Pathology reports <input type="checkbox"/> Lab results <input type="checkbox"/> Emergency services
<input type="checkbox"/> Obstetrics (labor and delivery) <input type="checkbox"/> Office/clinic notes <input type="checkbox"/> Respiratory reports <input type="checkbox"/> Circle One: FMLA, Power of Attorney, Pre-Admission Screening & Resident Review	
<input type="checkbox"/> Other (specify): _____	

ADDITIONAL REQUESTS	The information to be released will cover the time period from: _____ to _____ Specific Date: _____
	<input type="checkbox"/> Cardiac Images (e.g., Cath/ECHO/EKG -- specify): _____
	<input type="checkbox"/> Radiology Images (specify): _____
	<input type="checkbox"/> Billing <input type="checkbox"/> Payment Records <input type="checkbox"/> Fetal Monitoring Strips <input type="checkbox"/> Pharmacy <input type="checkbox"/> Home Care Services



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PURPOSE OF RELEASE	<input type="checkbox"/> Patient Care	<input type="checkbox"/> Appointment/Sharing with other health care provider as needed
	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Disability/Insurance Application/Claim
	<input type="checkbox"/> Administrative (i.e., FMLA)	<input type="checkbox"/> Attorney/Legal Case <input type="checkbox"/> Other (specify): _____

Authorization for Release of Medical Information

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.

PLEASE CHECK THE STATEMENT BELOW THAT APPLIES

(You must check one): I do _____ do not _____ authorize this information to be released.

I would like to limit the information to: _____

I understand that:

- I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
- I understand that this authorization will expire when the records are released for the request dated below. Any requests after this date will need a separate authorization.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.
- I get a copy of this form after I sign it.

Printed Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____ Date: _____ Time: _____

Relationship to Patient: _____